# Application for Health Coverage & Help Paying Costs

maryland health connection℠

THINGS TO KNOW

## Use this application to see what coverage choices you qualify for

- Affordable private health insurance plans that offer comprehensive coverage to help you stay well
- A new tax credit that can immediately help pay your premiums for health coverage
- Free or low-cost insurance from Medicaid or the Maryland Children's Health Program (MCHP)

**You may qualify for a free or low-cost program even if you earn as much as $94,000 a year (for a family of 4).**

## Who can use this application?

- Use this application to apply for anyone in your family.
- Apply even if you or your child already has health coverage. You could be eligible for lower-cost or free coverage.
- If you're single, you may be able to use a short form. Visit MarylandHealthConnection.gov.
- Families that include immigrants can apply. You can apply for your child even if you aren't eligible for coverage. Applying won't affect your immigration status or chances of becoming a permanent resident or citizen.
- If someone is helping you fill out this application, you may need to complete Appendix C.

## Apply faster online

Apply faster online at MarylandHealthConnection.gov.

## What you may need to apply

- Social Security Numbers (or document numbers for any legal immigrants who need insurance)
- Employer and income information for everyone in your family (for example, from paystubs, W-2 forms, or wage and tax statements)
- Policy numbers for any current health insurance
- Information about any job-related health insurance available to your family

## Why do we ask for this information?

We ask about income and other information to let you know what coverage you qualify for and if you can get any help paying for it. **We'll keep all the information you provide private and secure, as required by law.** To view the Privacy Act Statement, go to MarylandHealthConnection.gov.

## What happens next?

Send your complete, signed application to the address on page 7. **If you don't have all the information we ask for, sign and submit your application anyway.** We'll follow-up with you within 1–2 weeks. You'll get instructions on the next steps to complete your health coverage. If you don't hear from us, visit MarylandHealthConnection.gov or call **1-855-642-8572**. Filling out this application doesn't mean you have to buy health coverage.

## Get help with this application

- **Online:** MarylandHealthConnection.gov
- **Phone:** Call our consumer support center at **1-855-642-8572.**
- **In person:** There may be counselors in your area who can help. Visit our website or call **1-855-642-8572** for more information.
- **En Español:** Llame a nuestro centro de ayuda gratis al **1-855-642-8572.**

NEED HELP WITH YOUR APPLICATION? Visit MarylandHealthConnection.gov or call us at **1-855-642-8572**. Para obtener una copia de este formulario en Español, llame **1-855-642-8572**. If you need help in a language other than English, call **1-855-642-8572** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-642-8573**.

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# STEP 1 Tell us about yourself.

(We need one adult in the family to be the contact person for your application.)

| | | | |
|---|---|---|---|
| 1. First name, Middle name, Last name, & Suffix | | | |
| 2. Home address (Leave blank if you don't have one.) | | | 3. Apartment or suite number |
| 4. City | 5. State | 6. ZIP code | 7. County |
| 8. Mailing address (if different from home address) | | | 9. Apartment or suite number |
| 10. City | 11. State | 12. ZIP code | 13. County |
| 14. Phone number ( ) – | | 15. Other phone number ( ) – | |

16. Do you want to get information about this application by email? ☐ Yes ☐ No

Email address: _____

17. What is your preferred spoken or written language (if not English)?

# STEP 2 Tell us about your family.

**Who do you need to include on this application?**

Tell us about all the family members who live with you. If you file taxes, we need to know about everyone on your tax return. (You don't need to file taxes to get health coverage).

**DO Include:**

- Yourself
- Your spouse
- Your children under 21 who live with you
- Your unmarried partner who needs health coverage
- Anyone you include on your tax return, even if they don't live with you
- Anyone else under 21 who you take care of and lives with you

**You DON'T have to include:**

- Your unmarried partner who doesn't need health coverage
- Your unmarried partner's children
- Your parents who live with you, but file their own tax return (if you're over 21)
- Other adult relatives who file their own tax return

The amount of assistance or type of program you qualify for depends on the number of people in your family and their incomes. This information helps us make sure everyone gets the best coverage they can.

**Complete Step 2 for each person in your family.** Start with yourself, then add other adults and children. If you have more than 2 people in your family, you'll need to make a copy of the pages and attach them. You don't need to provide immigration status or a Social Security Number (SSN) for family members who don't need health coverage. We'll keep all the information you provide private and secure as required by law. We'll use personal information only to check if you're eligible for health coverage.

# STEP 2: PERSON 1 (Start with yourself)

Complete Step 2 for yourself, your spouse/partner and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you? **SELF**

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___

**We need this if you want health coverage and have an SSN.** Providing your SSN can be helpful if you don't want health coverage too since it can speed up the application process. We use SSNs to check income and other information to see who's eligible for help with health coverage costs. If someone wants help getting an SSN, call 1-800-772-1213 or visit socialsecurity.gov. TTY users should call 1-800-325-0778.

6. **Do you plan to file a federal income tax return NEXT YEAR?**
*(You can still apply for health insurance even if you don't file a federal income tax return.)*

☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.

a. Will you file jointly with a spouse? ☐ Yes ☐ No

**If yes,** name of spouse: _____

b. Will you claim any dependents on your tax return? ☐ Yes ☐ No

**If yes,** list name(s) of dependents: _____

c. Will you be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

**If yes,** please list the name of the tax filer: _____

How are you related to the tax filer? _____

7. Are you pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____

8. **Do you need health coverage?**
*(Even if you have insurance, there might be a program with better coverage or lower costs.)*

☐ YES. **If yes,** answer all the questions below. ☐ NO. **If no,** SKIP to the income questions on page 3. Leave the rest of this page blank.

9. Do you have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

10. Are you a U.S. citizen or U.S. national? ☐ Yes ☐ No

11. **If you aren't a U.S. citizen or U.S. national,** do you have eligible immigration status?

☐ Yes. Fill in your document type and ID number below.

a. Immigration document type _____ b. Document ID number _____

c. Have you lived in the U.S. since 1996? ☐ Yes ☐ No

d. Are you, or your spouse or parent a veteran or an active-duty member of the U.S. military? ☐ Yes ☐ No

12. Do you want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

13. Do you live with at least one child under the age of 19, and are you the main person taking care of this child? ☐ Yes ☐ No

14. Are you a full-time student? ☐ Yes ☐ No

15. Were you in foster care at age 18 or older? ☐ Yes ☐ No

16. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

17. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

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# STEP 2: PERSON 1 (Continue with yourself)

## Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 18.

☐ **Not employed**
Skip to question 28.

☐ **Self-employed**
Skip to question 27.

### CURRENT JOB 1:

18. Employer name and address

19. Employer phone number
( ) –

20. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

21. Average hours worked each WEEK

### CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

22. Employer name and address

23. Employer phone number
( ) –

24. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

25. Average hours worked each WEEK

26. **In the past year, did you:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

27. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

28. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None

☐ Unemployment $ _____ How often? _____

☐ Pensions $ _____ How often? _____

☐ Social Security $ _____ How often? _____

☐ Retirement accounts $ _____ How often? _____

☐ Alimony received $ _____ How often? _____

☐ Net farming/fishing $ _____ How often? _____

☐ Net rental/royalty $ _____ How often? _____

☐ Other income $ _____ How often? _____

Type: _____

29. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If you pay for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

**NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 27b).

☐ Alimony paid $ _____ How often? _____

☐ Student loan interest $ _____ How often? _____

☐ Other deductions $ _____ How often? _____

Type: _____

30. **YEARLY INCOME:** **Complete only if your income changes from month to month.**

**If you don't expect changes to your monthly income, skip to the next person.**

| Your total income **this year** | Your total income **next** year (if you think it will be different) |
|---|---|
| $ | $ |

## THANKS! This is all we need to know about you.

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# STEP 2: PERSON 2

Complete Step 2 for yourself, your spouse/partner, and children who live with you and/or anyone on your same federal income tax return if you file one. See page 1 for more information about who to include. If you don't file a tax return, remember to still add family members who live with you.

1. First name, Middle name, Last name, & Suffix

2. Relationship to you?

3. Date of birth (mm/dd/yyyy)

4. Sex ☐ Male ☐ Female

5. Social Security number (SSN) ___ ___ ___ - ___ ___ - ___ ___ ___ ___
**We need this if you want health coverage and have an SSN.**

6. Does PERSON 2 live at the same address as you? ☐ Yes ☐ No

**If no,** list address: _____

7. **Does PERSON 2 plan to file a federal income tax return NEXT YEAR?**
*(You can still apply for health insurance even if you don't file a federal income tax return.)*

☐ YES. **If yes,** please answer questions a–c. ☐ NO. **If no,** skip to question c.

a. Will PERSON 2 file jointly with a spouse? ☐ Yes ☐ No

**If yes,** name of spouse: _____

b. Will PERSON 2 claim any dependents on his or her tax return? ☐ Yes ☐ No

**If yes,** list name(s) of dependents: _____

c. Will PERSON 2 be claimed as a dependent on someone's tax return? ☐ Yes ☐ No

**If yes,** please list the name of the tax filer: _____

How is PERSON 2 related to the tax filer? _____

8. Is PERSON 2 pregnant? ☐ Yes ☐ No a. **If yes,** how many babies are expected during this pregnancy? _____

9. **Does PERSON 2 need health coverage?**
*(Even if they have insurance, there might be a program with better coverage or lower costs.)*

☐ YES. **If yes**, answer all the questions below. ☐ NO. **If no,** SKIP to the income questions on page 5. Leave the rest of this page blank.

10. Does PERSON 2 have a physical, mental, or emotional health condition that causes limitations in activities (like bathing, dressing, daily chores, etc) or live in a medical facility or nursing home? ☐ Yes ☐ No

11. Is PERSON 2 a U.S. citizen or U.S. national? ☐ Yes ☐ No

12. **If PERSON 2 isn't a U.S. citizen or U.S. national,** do they have eligible immigration status?

☐ Yes. Fill in their document type and ID number below.

a. Document type _____ b. Document ID number _____

c. Has PERSON 2 lived in the U.S. since 1996? ☐ Yes ☐ No

d. Is PERSON 2, or their spouse or parent a veteran or an active-duty member in the U.S. military? ☐ Yes ☐ No

13. Does PERSON 2 want help paying for medical bills from the last 3 months? ☐ Yes ☐ No

14. Does PERSON 2 live with at least one child under the age of 19, and are they the main person taking care of this child? ☐ Yes ☐ No

15. Was PERSON 2 in foster care at age 18 or older? ☐ Yes ☐ No

**Please answer the following questions if PERSON 2 is 22 or younger:**

16. Did PERSON 2 have insurance through a job and lose it within the past 3 months? ☐ Yes ☐ No

a. **If yes**, end date: _____ b. Reason the insurance ended: _____

17. Is PERSON 2 a full-time student? ☐ Yes ☐ No

18. **If Hispanic/Latino, ethnicity (OPTIONAL—check all that apply.)**

☐ Mexican ☐ Mexican American ☐ Chicano/a ☐ Puerto Rican ☐ Cuban ☐ Other _____

19. **Race (OPTIONAL—check all that apply.)**

☐ White
☐ Black or African American
☐ American Indian or Alaska Native
☐ Asian Indian
☐ Chinese
☐ Filipino
☐ Japanese
☐ Korean
☐ Vietnamese
☐ Other Asian
☐ Native Hawaiian
☐ Guamanian or Chamorro
☐ Samoan
☐ Other Pacific Islander
☐ Other _____

**Now, tell us about any income from PERSON 2 on the back.**

**NEED HELP WITH YOUR APPLICATION?** Visit MarylandHealthConnection.gov or call us at **1-855-642-8572**. Para obtener una copia de este formulario en Español, llame **1-855-642-8572**. If you need help in a language other than English, call **1-855-642-8572** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-642-8573**.

# STEP 2: PERSON 2

## Current Job & Income Information

☐ **Employed**
If you're currently employed, tell us about your income. Start with question 20.

☐ **Not employed**
Skip to question 30.

☐ **Self-employed**
Skip to question 29.

### CURRENT JOB 1:

20. Employer name and address

21. Employer phone number
( ) –

22. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

23. Average hours worked each WEEK

### CURRENT JOB 2: (If you have more jobs and need more space, attach another sheet of paper.)

24. Employer name and address

25. Employer phone number
( ) –

26. Wages/tips (before taxes) ☐ Hourly ☐ Weekly ☐ Every 2 weeks ☐ Twice a month ☐ Monthly ☐ Yearly

$ _____

27. Average hours worked each WEEK

28. **In the past year, did PERSON 2:** ☐ Change jobs ☐ Stop working ☐ Start working fewer hours ☐ None of these

29. **If self-employed, answer the following questions:**

a. Type of work

_____

b. How much net income (profits once business expenses are paid) will you get from this self-employment this month?

$ _____

30. **OTHER INCOME THIS MONTH:** Check all that apply, and give the amount and how often you get it.

**NOTE:** You don't need to tell us about child support, veteran's payment, or Supplemental Security Income (SSI).

☐ None
☐ Unemployment $ _____ How often? _____
☐ Pensions $ _____ How often? _____
☐ Social Security $ _____ How often? _____
☐ Retirement accounts $ _____ How often? _____
☐ Alimony received $ _____ How often? _____
☐ Net farming/fishing $ _____ How often? _____
☐ Net rental/royalty $ _____ How often? _____
☐ Other income $ _____ How often? _____
Type: _____

31. **DEDUCTIONS:** Check all that apply, and give the amount and how often you get it.

If PERSON 2 pays for certain things that can be deducted on a federal income tax return, telling us about them could make the cost of health coverage a little lower.

**NOTE:** You shouldn't include a cost that you already considered in your answer to net self-employment (question 29b).

☐ Alimony paid $ _____ How often? _____
☐ Student loan interest $ _____ How often? _____
☐ Other deductions $ _____ How often? _____
Type: _____

32. **YEARLY INCOME:** **Complete only if PERSON 2's income changes from month to month.**

If you don't expect changes to PERSON 2's monthly income, add another person or skip to the next section.

| PERSON 2's total income **this year** | PERSON 2's total income **next year** (if you think it will be different) |
|---|---|
| $ | $ |

## THANKS! This is all we need to know about PERSON 2.

**If you have more than two people to include, make a copy of Step 2: Person 2 (pages 4 and 5) and complete.**

**NEED HELP WITH YOUR APPLICATION?** Visit MarylandHealthConnection.gov or call us at **1-855-642-8572**. Para obtener una copia de este formulario en Español, llame **1-855-642-8572**. If you need help in a language other than English, call **1-855-642-8572** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-642-8573**.

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# STEP 3 American Indian or Alaska Native (AI/AN) family member(s)

## 1. Are you or is anyone in your family American Indian or Alaska Native?

☐ If **No,** skip to Step 4.

☐ **Yes. If yes,** go to Appendix B.

# STEP 4 Your Family's Health Coverage

Answer these questions for anyone who needs health coverage.

1. **Is anyone enrolled in health coverage now from the following?**

☐ YES. **If yes**, check the type of coverage and write the person(s)' name(s) next to the coverage they have. ☐ NO.

☐ Medicaid _____

☐ MCHP _____

☐ Medicare _____

☐ TRICARE (Don't check if you have direct care or Line of Duty)

_____

☐ VA health care programs _____

☐ Peace Corps _____

☐ Employer insurance _____

Name of health insurance: _____

Policy number: _____

Is this COBRA coverage? ☐ Yes ☐ No

Is this a retiree health plan? ☐ Yes ☐ No

☐ Other

Name of health insurance: _____

Policy number: _____

Is this a limited-benefit plan (like a school accident policy)?

☐ Yes ☐ No

2. **Is anyone listed on this application offered health coverage from a job?** Check yes even if the coverage is from someone else's job, such as a parent or spouse.

☐ YES. **If yes,** you'll need to complete and include Appendix A. Is this a state employee benefit plan? ☐ Yes ☐ No

☐ NO. **If no, continue to Step 5.**

# STEP 5 Read & sign this application.

- I'm signing this application under penalty of perjury which means I've provided true answers to all the questions on this form to the best of my knowledge. I know that I may be subject to penalties under federal law if I provide false and or untrue information.
- I know that I must tell Maryland Health Connection if anything changes (and is different than) what I wrote on this application. I can visit MarylandHealthConnection.gov or call **1-855-642-8572** to report any changes. I understand that a change in my information could affect the eligibility for member(s) of my household.
- I know that under federal law, discrimination isn't permitted on the basis of race, color, national origin, sex, age, sexual orientation, gender identity, or disability. I can file a complaint of discrimination by visiting www.hhs.gov/ocr/office/file.
- I confirm that no one applying for health insurance on this application is incarcerated (detained or jailed). If not, _____ is incarcerated.
  (name of person)

We need this information to check your eligibility for help paying for health coverage if you choose to apply. We'll check your answers using information in our electronic databases and databases from the Internal Revenue Service (IRS), Social Security, the Department of Homeland Security, and/or a consumer reporting agency. If the information doesn't match, we may ask you to send us proof.

### Renewal of coverage in future years

To make it easier to determine my eligibility for help paying for health coverage in future years, I agree to allow the marketplace to use income data, including information from tax returns. The marketplace will send me a notice, let me make any changes, and I can opt out at any time.

Yes, renew my eligibility automatically for the next

☐ 5 years (the maximum number of years allowed), or for a shorter number of years:

☐ 4 years ☐ 3 years ☐ 2 years ☐ 1 year ☐ Don't use information from tax returns to renew my coverage.

### If anyone on this application is eligible for Medicaid

- I am giving to the Medicaid agency our rights to pursue and get any money from other health insurance, legal settlements, or other third parties. I am also giving to the Medicaid agency rights to pursue and get medical support from a spouse or parent.
- Does any child on this application have a parent living outside of the home? ☐ Yes ☐ No
- If yes, I know I will be asked to cooperate with the agency that collects medical support from an absent parent. If I think that cooperating to collect medical support will harm me or my children, I can tell Medicaid and I may not have to cooperate.

### My right to appeal

If I think Maryland Health Connection or Medicaid/Maryland Children's Health Program (MCHP) has made a mistake, I can appeal its decision. To appeal means to tell someone at Maryland Health Connection or Medicaid/MCHP that I think the action is wrong, and ask for a fair review of the action. I know that I can find out how to appeal by contacting the marketplace at **1-855-642-8572**. I know that I can be represented in the process by someone other than myself. My eligibility and other important information will be explained to me.

**Sign this application.** The person who filled out Step 1 should sign this application. If you're an authorized representative you may sign here, as long as you have provided the information required in Appendix C.

| Signature | Date (mm/dd/yyyy) |
|---|---|
| | |

# STEP 6 Mail completed application.

Mail your signed application to:

**Maryland Health Connection**
**P.O. Box 857**
**Lanham, MD 20703-0857**

If you want to register to vote, you can complete a voter registration form at www.eac.gov/NVRA.

**NEED HELP WITH YOUR APPLICATION?** Visit MarylandHealthConnection.gov or call us at **1-855-642-8572**. Para obtener una copia de este formulario en Español, llame **1-855-642-8572**. If you need help in a language other than English, call **1-855-642-8572** and tell the customer service representative the language you need. We'll get you help at no cost to you. TTY users should call **1-855-642-8573**.



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